



Supporting Family Cultures, Values, and Languages

Module 2

Partnering with Families as They Guide the Way

Supporting Family Cultures, Values, and Languages



Supporting Family Cultures, Values, and Languages

For optimal development and learning of all children, individuals who work with children must respect, value, and support the *culture, values, and languages* of each home and promote the active participation of all families.

NAEYC's Position Statement on Responding to Linguistic and Cultural Diversity (1995).





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Definition of terms:

Culture refers to “shared and learned ideas and products of a society. It is the shared way of life of a people, including the beliefs, their technology, their values and norms, all of which are transmitted down through the generations by learning and observation.” (Small, 1998, p.72)

Values refers to “emotionally laden beliefs about what is right or wrong, appropriate or inappropriate, desirable or offensive.” (CLAS Early Childhood Research Institute, 1998, p.9)

Position Statement on Responsiveness to Family Cultures, Values, and Languages. (Approved: April, 2002). Division of Early Childhood. Missoula, Montana.



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“Legislation and recommended practices call for individualized approaches to serving infants, toddlers, and young children with special needs and their families.”

“Individualized services begin with responsiveness to differences in race, ethnicity, culture, language, religion, education, income, family configuration, geographic location, ability, and other characteristics that contribute to human uniqueness.”

Position Statement on Responsiveness to Family Cultures, Values, and Languages. (Approved: April, 2002). Division of Early Childhood. Missoula, Montana.



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“Responsiveness grows from interpersonal relationships that reflect a mutual respect and appreciation for individuals’ culture, values, and language.”

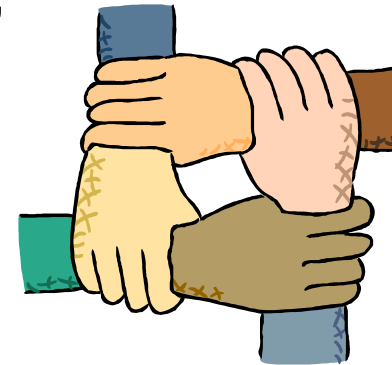
“Responsive early childhood programs and professionals honor the values and practices within the families being served as well as among people providing the services.”

Position Statement on Responsiveness to Family Cultures, Values, and Languages. (Approved: April, 2002). Division of Early Childhood. Missoula, Montana.



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“The United States is one of the most culturally, ethnically, racially, and linguistically diverse countries in the world...It is useful for professionals to develop a common foundation of knowledge and practical strategies to address the needs of the families they serve, especially when families’ backgrounds are different from their own.”



Bruns, D. & Corso, R. (2001). *Working with Culturally & Linguistically Diverse Families*. ERIC DIGEST. Champaign, IL. University of Illinois. ERIC Clearinghouse on Elementary and Early Childhood Education.



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“A variety of interrelated issues and personal characteristics influence the development of relationships between professionals and those they serve, including:

- Family structure
- Age
- Length of time since immigration
- Cultural expectations about early childhood services and outcomes.”

Bruns, D. & Corso, R. (2001). *Working with Culturally & Linguistically Diverse Families*. ERIC DIGEST. Champaign, IL. University of Illinois. ERIC Clearinghouse on Elementary and Early Childhood Education.



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“Service providers’ beliefs or values regarding child rearing, early intervention, parental advocacy, communication, and everyday activities related to feeding, sleeping arrangements, toileting and play may differ from those of some of the families they serve (Gonzalez-Mena, 1997).”

Bennett, T., et.al. (2001). *Cross-cultural considerations in early childhood special education* (CLAS Technical Report #14). Champaign, IL. University of Illinois at Urbana-Champaign, Early Childhood Research Institute on Culturally and Linguistically Appropriate Services.



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Service providers can increase their cultural self-awareness by:

- Reading and studying other cultures
- Utilizing knowledgeable individuals from the respective cultures as guides or mediators
- Actively participating in the culture

Bennett, T., et.al. (2001). *Cross-cultural considerations in early childhood special education* (CLAS Technical Report #14). Champaign, IL. University of Illinois at Urbana-Champaign, Early Childhood Research Institute on Culturally and Linguistically Appropriate Services.



Supporting Family Cultures, Values, and Languages

by:

- Learning the language of the culture
- Learning about the cultural community's view on disability, social services, medical care, child-rearing practices, decision-making practices, religious influences, and beliefs about health and healing



Bennett, T., et.al. (2001). *Cross-cultural considerations in early childhood special education* (CLAS Technical Report # 14). Champaign, IL. University of Illinois at Urbana-Champaign, Early Childhood Research Institute on Culturally and Linguistically Appropriate Services.



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“Cultural differences in communicative strategies and competencies have major implications for how we convey information, assess children’s progress, and recommend and implement interventions.”



Bennett, T., et.al. (2001). *Cross-cultural considerations in early childhood special education* (CLAS Technical Report #14). Champaign, IL. University of Illinois at Urbana-Champaign, Early Childhood Research Institute on Culturally and Linguistically Appropriate Services.



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“Communicative competence extends to both knowledge and expectation of who may or may not speak in certain settings, when to speak and when to remain silent, whom one may speak to, how one may talk to persons of different statuses and roles, what appropriate nonverbal behaviors are in various contexts, what the routines for turn-taking are in conversations, how to ask for and give information, how to request, how to offer or decline assistance or cooperation, how to give commands, how to enforce discipline, and the like – in short, everything involving the use of language and other communicative dimensions in particular social settings.”

Bennett, T., et.al. (2001). *Cross-cultural considerations in early childhood special education* (CLAS Technical Report #14). Champaign, Illinois, University of Illinois at Urbana-Champaign, Early Childhood Research Institute on Culturally and Linguistically Appropriate Services.



Supporting Family Cultures, Values, and Languages

Research Supported Strategies for Partnering with Families in Early Childhood

- 1. Respect the uniqueness of each family system*
- 2. Develop a personalized relationship with families*
- 3. Communicate in culturally appropriate ways*
- 4. Recruit staff who view diversity as an asset*
- 5. Create alliances with cultural guides*
- 6. Evaluate process and outcomes*

Bruns, D. & Corso, R. (2001). *Working with Culturally & Linguistically Diverse Families*. ERIC DIGEST. Champaign, IL. University of Illinois. ERIC Clearinghouse on Elementary and Early Childhood Education.



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“Variations in belief systems exist within and between ethnic groups. Each family has its own distinct beliefs about illness, disability, and health. Generalizations about families cannot be made based on ethnicity, socio-economic status, religion, education, and geographical location.”

“Traditional beliefs are embedded in each family’s daily life.”



Bennett, T., et.al. (2001). *Cross-cultural considerations in early childhood special education* (CLAS Technical Report #14). Champaign, IL. University of Illinois at Urbana-Champaign, Early Childhood Research Institute on Culturally and Linguistically Appropriate Services.



Supporting Family Cultures, Values, and Languages

“Keeping in mind the individuality of a family as a unit and having specific knowledge of a family’s interpretation of disability, health beliefs, and expectations for the child’s role in a society will help professionals anticipate and understand why a family makes certain decisions about the child’s early intervention services and health care.”



Bennett, T., et.al. (2001). *Cross-cultural considerations in early childhood special education* (CLAS Technical Report #14). Champaign, IL. University of Illinois at Urbana-Champaign, Early Childhood Research Institute on Culturally and Linguistically Appropriate Services.



Supporting Family Cultures, Values, and Languages

“Perceptions of disability can influence family decisions about child-rearing, utilizing social services, and seeking medical care. These beliefs and perceptions about disability are important for early intervention professionals to understand and to respect. A true understanding of this concept is critical, as are the potential positive outcomes of working more effectively with families utilizing a family-centered philosophy.”

Bennett, T., et.al. (2001). *Cross-cultural considerations in early childhood special education* (CLAS Technical Report #14). Champaign, IL. University of Illinois at Urbana-Champaign, Early Childhood Research Institute on Culturally and Linguistically Appropriate Services.

Technical Report #14

2001

by Tess Bennett, Janet Eatman, Georgia Earnest Garcia, James Halle, Jeanette McCollum, Micki Ostrosky, Laura Hojnar Tarnow, Ruth Watkins, Tweety Yates, and Chun Zhang

<http://clas.uiuc.edu/techreport/tech14.html#3> [Online] Retrieved 2004, March 29.

Cross-Cultural Considerations in Early Childhood Special Education

Chapter III Multicultural Views of Disability

Tess Bennett, Chun Zhang and Laura Hojnar Tarnow

The complexity of the belief systems and values affecting the perception of disability is central to understanding culturally and linguistically diverse families. These perceptions of disability are an important dimension of the history and tradition of many cultures. They are embedded in the everyday fabric of life and are not likely to change quickly. Perceptions of disability can influence family decisions about child-rearing, utilizing social services, and seeking medical care. These beliefs and perceptions about disability are important for early intervention professionals to understand and to respect. A true understanding of this concept is critical, as are the potential positive outcomes of working more effectively with families utilizing a family-centered philosophy.

The family's perception of disability may influence a family's decision in seeking early intervention services for the child with a disability. Groce and Zola (1993) point out that "many ethnic minority populations do not define or address disability and chronic illness in the same manner as mainstream American culture" (p. 1048). Atkins (1991) indicates that professionals from the European American culture often hold a medicalized view when they interpret disability. Such a view states that disabling conditions, being scientifically determined, exist within the individuals and that disabling conditions should be fixed with some remedy. Harry and Kalyanpur (1994) argue that the notion of disability is a matter of meaning, rather than a fact that can be objectively measured, especially in the case of mild disabilities. They point out that professionals who see disability as a condition inherent in an individual through a medicalized view in which scientific explanations are preferred may come into conflict with families having differing perceptions of disability.

Variations in belief systems exist within and between ethnic groups. Each family has its own distinct beliefs about illness, disability, and health. Generalizations about families cannot be made based on ethnicity, socio-economic status (SES), religion, education, and geographical location. For example, many second- or third-generation Asian adults may not share beliefs about disability with their parents who hold more traditional beliefs. Culturally diverse families who reside in the community where the majority of the residents are European American families may be more assimilated by the European

American culture and health practice. Keeping in mind the individuality of a family as a unit and having specific knowledge of a family's interpretation of disability, health beliefs, and expectations for the child's roles in a society will help professionals anticipate and understand why a family makes certain decisions about the child's early intervention services and health care.

In order to understand a family's perception of disability and the tremendous impact of these beliefs, it is helpful to understand beliefs about the cause of a chronic illness or disability, expectations for survival for the child with a disability, and the social roles that are appropriate for children who are disabled or chronically ill in a given culture (Groce & Zola, 1993). In this chapter, beliefs about disability, beliefs about health and healing, and expectations of the child's social roles will be discussed. Examples of perception of disability from culturally diverse families will be given for better understanding of these families. Guiding questions will be presented for professionals and for reviewing materials on the perception of disability.

Meaning of Disability

The way in which families perceive and interpret disability is of great importance because these perceptions may affect their attitudes toward their children with a disability (Lowenthal, 1996). Hughes (1992) indicates that the effect of the birth of a child with a disability changes family functioning and interaction. The way a child is perceived may depend on the family's traditional values, SES, support and resources. In many cultures, children with disabilities and their families are believed to be cursed by God, and the disability may be considered as a form of punishment for past sins (Lowenthal, 1996). Whether negative or positive, the meaning of disability significantly affects the family's adaptation to raising the child with a disability as well as decision-making in seeking services for the child. Traditional beliefs, spiritual beliefs or rituals, and religion play a very important role in shaping the meaning of disability for the family.

Traditional and Spiritual Beliefs

Traditional beliefs are embedded in each family's daily life. Families may rely on their traditional and spiritual beliefs for the interpretation of disability. Examples of the traditional beliefs about disability from representative families of culturally diverse backgrounds may shed some light on their differing perceptions of disability.

For example, Groce and Zola (1993) indicate that witchcraft is strongly linked to chronic illness and disability in a number of African societies. The individual with chronic illness or disability may be perceived as being witched, and close association with that individual may put others at risk for witchcraft. Similarly, some African Americans might attribute the cause of illness or disability to punishment from God or evil spirits (Willis, 1992).

Chan (1992) wrote that among many Asian ethnic groups, moderate to severe disabilities are traditionally viewed with considerable stigma. Traditional attributions regarding specific disabilities vary from person to person and from group to group. Chan (1992) states that Asian individuals who hold onto traditional beliefs may perceive a disability as evidence for transgressions committed in a previous life. Many families of Asian origin may attribute the child's disability to the moral wrongdoing (e.g., gambling) committed by the child or the child's ancestors in a previous life. The child's disability may be viewed as a form of divine punishment for past sins and moral transgressions. Spiritual explanations of the cause of disability often focus on evil spirits. Evil spirits such as demons or ghosts are believed to be involved in causing the disability. Many mothers of Asian origin may turn to naturalistic or metaphysical attributions. They may blame themselves for causing the child's disability by failing to follow a certain dietary and health care practice during pregnancy, or they may blame themselves for violating certain taboos. Some of these taboos include looking at certain ugly animals, knitting, using scissors, and attending a funeral (Chan, 1992).

Groce and Zola (1993) indicate that many Southeast Asian families may also attribute the cause of a chronic illness and disability to an imbalance of elements or humors in the body. The affected individual is supposed to take responsibility for the disability. The cause and the potential cure lie within the individual, who must try to reestablish equilibrium. D'Avanzo (1992) states that many Southeast Asian individuals may ascribe an infant's abnormalities to the wrong foods or activities or punishment for actions of the mother or the baby in a previous life. They may give up on infants with a severe disability or illness because they believe the child will suffer less in the next reincarnation. However, some cultural explanations of the causes of disability are quite positive. An example is a Hmong family who refused surgery for their son's club foot because the condition was viewed as a blessing for the whole community (Hmong family, 1991, as cited in Harry & Kalyanpur, 1994).

Risser and Mazur (1995) wrote that many families of Hispanic origin believe that the disability may have resulted from divine punishment for a crime committed by the pregnant woman or her family. They may also believe that a pregnant woman can cause permanent damage to her fetus by making fun of someone with a physical defect or by experiencing great emotional distress while pregnant. In addition, rare acts of nature, such as a hurricane or earthquake, are sometimes believed to cause a pregnant woman to have a child with a disability. Evil intentions of others or evil lurking in pregnant women are believed to cause disability in their offspring.

Garret, Michael, Tlanusta, and Myers (as cited in Harry and Kalyanpur, 1994) indicate that many Native Americans believe that life moves in related circles. This constant motion of life should not be disturbed. Each individual serves a purpose in life that is interrelated to every other individual. The belief that all things are alive and have spiritual importance contributes to the balance and harmony of nature. Discord results when one loses sight of one's place in the universe. For this reason, choice is extremely important. Each individual may strive for harmony and try to make the right choices to maintain personal equilibrium and the group's equilibrium with nature (Garret et. al., as cited in

Harry & Kalyanpur, 1994). When an individual is born with a disability in a Native American community, there may be a strong belief that the disability was meant to be. Attempts to fix the disabled person may upset the balance, which includes his or her contribution to the group. The individual is not seen as deficient; instead, the individual contributes to the community in his/her own way regardless of disability. Further, if the condition does not seem problematic to the family, it is unlikely that they will respond favorably to the notion of treatment. In other words the family may accept the fact that the child is functioning as well as his/her abilities allow. Many Native Americans accept the fact that each family member will be different to some degree. This is viewed as the natural cycle in which life moves (McCubbin, Thompson, Thompson, McCubbin, and Kaston, 1993).

These examples about the meaning of disability from some culturally diverse families may help early childhood professionals understand families' attitudes toward disability. Professionals should accept and respect instead of judging and criticizing families' traditional beliefs. Religious beliefs may also shape a family's interpretation of disability.

Religion

Families' religious beliefs are very important to the interpretations of disability. Some families may believe that the appearance of a child's disability comes from God's will and that raising a child with a disability is a sacred task for the family; whereas, some families may believe that disability is a form of punishment from God. Whatever religious meaning of disability a family may have, these interpretations may affect the family's adaptation to childrearing and family functioning. Examples from some culturally diverse families are presented in the following section to illustrate the impact of religious views.

Dulan and Blacher (1995) indicate that many African Americans believe in God as a supreme being and believe all people are "God's children," including those with disabilities. The disabled are valued members of the family. Belief in a supreme being may provide support for a family raising a child with disability. Family members may think that a supreme being is in control and the family will be helped through suffering and hardships.

Some Hispanic families may have specific ideas of why and how a child obtained a disability. These beliefs may affect the family's understanding of the disability and the resulting treatments. These culturally distinct views of the cause of the disability are usually associated with religious beliefs and superstition. Intense religious faith is also a value of many individuals in Hispanic cultures. The dominant organized religions are Roman Catholic, Pentecostal, Seventh Day Adventist, and Jehovah's Witness churches. The Roman Catholic church has been known as the primary religion of many Hispanic cultures. Because of the strong religious beliefs of some Hispanic families, a child with a disability is usually viewed as a child of God. The family may feel they have a religious duty to care for the child with a disability (Heller, Markwardt, Rowitz, & Farber, 1994).

Moreover, research has shown an increased level of participation in churches in some Hispanic communities if the family includes a disabled member. The church may serve as an informal support to the family and the individual who is disabled. Faith in a higher power is a commitment in many Hispanic families (Harrison, Wodarski, & Thyer, 1992).

If families believe that disability is a punishment for past wrongs, this belief can be a deterrent to seeking early intervention services for the child with disability. On such occasions, the child may be isolated and hidden and assistance may not be promoted. It is very important for professionals to be aware of the traditional and religious beliefs of the family to determine if the family holds a negative, positive, or a continuum of views of disability. In addition, understanding families' beliefs about health and healing can help professionals identify why the family seeks certain health care and treatments for the child's disability.

Beliefs about Health and Healing

Each family, as a critical social unit, has cultural beliefs and practices regarding health, illness, and disability. Ahmann (1994) explains that the European American culture tends to view illness as foreign and intrusive with the cause being outside of the family (e.g., virus, infection). These families generally see the goal of treatment to be caring for or fixing problems. Other families may view illness or disability as originating from within the family (e.g., past wrongs, moral wrongdoing) and rely on a spiritual cure as one of the treatments. The type of health care and healing families seek may be determined by the degree families believe in folk medicine and treatment, Western medicine and technology, or in a combination of both.

Beliefs about Folk Medicine and Folk Healers

Health beliefs and practices vary considerably within and between cultural groups. Many families, especially those who are recent immigrants or those who are not familiar with the health care system in the United States, may rely on traditional medicine and healing for treatments. Being aware of the differing health beliefs of culturally diverse families may help professionals find a balance between being sensitive to these traditional health practices and using scientific medical judgment about effective treatments (Becerra & Inglehart, 1995). Understanding traditional treatments may help early interventionists and other professionals provide more appropriate treatments and services to children with disabilities and their families.

Willis (1992) wrote that some African American families who live in rural areas may prefer a holistic and natural approach to health. Some African Americans who believe in folk medicine may think that illness is either natural or unnatural. Natural illnesses are caused by nature's forces such as bad weather conditions, bad food, or water. They may use herbs, roots, teas, and foods for preventive and healing practices. Unnatural illnesses could be caused by evil forces such as voodoo and witchcraft. Groce and Zola (1993)

indicate that some African American families, especially those strongly affiliated with the church, may hope for a miracle to heal the child. These families may hope that the doctors are wrong and think that God will make the child better. Anderson (1989) indicates that traditional cultural healers may be important to many African American families. Cultural healers may be highly respected for the physical and emotional support they provide to their patients. They may also be an asset to aid the provision of early intervention services.

In many Asian cultures, traditional Chinese medicine has had a significant impact on the health beliefs of individuals from many countries (e.g., Korea, Japan, Vietnam, Laos, and Cambodia) (Chan, 1992). Traditional Chinese medicine attributes illness to metaphysical causes. In most Asian cultures, illness and disease are thought to be caused by both internal and external factors (Tom, 1989). The holistic philosophy of Chinese medicine does not separate mental illness from physical illness. Keeping harmony between yin (cold) and yang (hot) forces of the body, mind, and emotions can maintain health (Chan, 1992). Some traditional treatment methods are herbs, self-restraint, meditation, and dermabrasive procedures including rubbing and cupping (McCormack, 1987). Traditional healers may use herbal medicines, acupuncture, and employ rubbing the "sick" area with a coin, or placing small heated cups over the area to draw out the "cold wind." These techniques originate from Chinese medicine which is based on principles of universal balance and harmony between the equal and opposite forces of yin and yang (D'Avanzo, 1992).

Folk medicine may emphasize the supernatural causes of illness and diseases. Many Southeast Asian families may believe that physical, emotional, and mental problems are associated with the loss of souls. Some Laotian and Hmong people believe that disease is caused by the wrath of gods (McCormack, 1987). The treatments are usually performed by or in consultation with a priest, shaman, or spiritual master using methods of soul calling, exorcism, chanting of sacred prayers, and other spiritual healing ceremonies (Kemp, 1985).

Many Hispanic families also hold traditional beliefs about disabilities and illness. These beliefs may play a crucial role in how the family will react to the child's disability. Many Hispanic families may rely on folk remedies to cure problems. These treatments vary greatly among the subcultures. Beliefs about the origin of the disability often influence choices for treatment. For example, if a Hispanic family believes that the child's disability was the result of someone transferring evil onto the child through staring at them with the evil eye, the family may want to use a folk remedy approach that will rid the child of the evil in their body (Groce & Zola, 1993). Some Hispanic families may want to implement a treatment for the child that employs both folk medicine practices and modern day practices (Krajewski-Jaime, 1991).

There are several types of folk remedies that are often highly regarded in the Hispanic community. The family may rely on "curanderos," who are faith healers, to assist and guide them in their decisions regarding the proper treatment (Risser & Mazur, 1995). Folk medicine concepts related to specific conditions, causes for the conditions and

specific treatments, foods, medicines and rituals are sometimes used. Folk healers may address particular needs experienced by individuals who are in distress and use unique culturally specific methods to diagnose and treat specific ailments. There are five types of folk healers that exist among the three largest groups of Hispanic origin in the U.S.: Puerto Ricans, Cubans, and Mexican Americans. The five types are called the Spiritist, Santero, Herbalist, Santiguador, and Curandero (Harrison, et. al., 1992).

Some Hispanic families may utilize these traditional healers when addressing specific concerns. Some folk medicine concepts include adherence to hot and cold balance, "mal de ojo" (evil eye), "caida de la mollera" (fallen fontanelle), "empacho" (stomach disorder) and "susto" or "ataque" (fright) (Risser & Mazur, 1995). Folk medicine remedies may be the first choice for some families to treat specific problems. Some Hispanic families, particularly those from rural areas, have great respect for faith healers and folk medicine remedies. These families may have used these traditional practices and spiritual rituals for generations.

Many Native American families may rely on their own health practices to assist a member of their community who is ill or disabled. The traditional healing practices that many Native American families follow may have been passed down for centuries. Many Native Americans view medicine as a spiritual rather than a biological concept. The medical practitioner for many Native American groups is called the Shaman or medicine man. The medicine man draws power from the Great Spirit in order to help his fellow man. There are many steps in the healing process, in which three different people will perform. The first person is the healer. He may use herbs and spiritual powers to heal. Next, there is the "tied one" who uses the power of the rawhide and stones in order to find a cure. Finally, there is the "conjurer" or "witch doctor" who may excavate the evil in a person's body. Herbs, ceremonies, sun dances, and sacred pipes are all methods that may be used to help an individual with problems or disability. The healing process is holistic incorporating the mind, body, and spirit (Garret et. al., as cited in Harry & Kalyanpur, 1994). These beliefs about health and healing may directly or indirectly influence a family's decision in seeking treatments for their child.

Western Medicine and Technology

Many families may not agree with the standard European American notion that a disability exists within the individual and that a disability needs to be fixed. The family's choice for seeking early intervention services and medical treatments for the child with a disability may be strongly determined by families' traditional beliefs about disability and health. In addition, family's SES (e.g., ability to buy health insurance), knowledge about early intervention and medical services, and accessibility of these services may affect a family's decisions.

In some Native American cultures, the individual serves a distinct purpose in nature and contributes to the balance and harmony of life for the tribe. These beliefs of some Native Americans may inhibit the use of modern day western medical practices. First, these

beliefs may contradict the philosophy behind western medical practices. Second, many Native Americans may be offended if medical doctors suggest and prescribe treatments that are meant to fix the person with a problem or disability and not acknowledge the potential and positive contributions that the individual may serve. For example, if a doctor recommends corrective surgery for a person with a disability, the family might see that as unnecessary (McCubbin, Thompson, et al., 1993). Sontag and Schacht (1993) report that Native American children in their sample were much less likely to have surgery and special medical care (e.g., genetic counseling, and special equipment and supplies). Some Native Americans may use western medicine only as a second opinion.

Many families may have a combined use of traditional or folk medicine and western medicine. For example, D'Avanzo (1992) indicates that western medicine and Chinese and folk medicine coexist in some cities in Southeast Asia. The poor who live in isolated areas usually turn to traditional methods of health care; whereas, the more affluent may go to western-style hospitals for medication and care. Health care for some families in Cambodia, Laos, and Vietnam is often crisis-oriented. Some Southeast Asian families may deal with illness by using self-care and self-medication.

Willis (1992) wrote that high technology medical care might be viewed by some less-educated or low-income families as care that is used in traumatic situations. Likewise, less-educated or low-income families of any culture may lack the knowledge how to locate and select family doctors. Sometimes families may be unaware of current health problems such as infant mortality, cancer, and AIDS, which may result in a lack of perception of major threats to their health (Willis, 1992). Due to the increasing number of American families who live in poverty, some families must wait for an illness to occur before seeking medical care (Willis, 1992). The health care system is usually a last resort for many low-income families (McCormack, 1987). Willis (1992) indicates that preventive health visits may not be sought, visits for infants and children may not be frequent, and many parents may not feel motivated to seek services for their children because they may find the eligibility procedures complicated, overwhelming, or offensive.

Professionals should realize that traditional healers are active within many communities. If professionals view traditional health beliefs as a legitimate topic for discussion, it may be beneficial in understanding the child, parents, and the entire family (Chao, 1992). Acknowledging a family's traditional beliefs and health practices should be blended with the standard medical diagnosis of the disability. Professionals need to balance the strengths and weaknesses of both views when working with families. Related to the meaning of disability and traditional health beliefs are the family's expectations for the survival and social participation of the child with a disability (Groce & Zola, 1993). A family's expectations for the child's survival and the child's social role are closely linked to a family's decision in accessing supports and services for the child.

Expectations of Child's Social Roles

Groce and Zola (1993) state that although sophisticated medical technologies in the United States can now ensure the physical survival of many at-risk children, many families may decide not to seek early intervention services for their children with disabilities. Some families may be very protective when taking care of their children; whereas, other families may be hiding their children from the public. Cultural expectations cannot be divided neatly according to specific ethnic groups. The manner in which a family believes their child with chronic illness or disability should be restored to health and their choice about seeking treatments and services may reflect their traditional expectations of the survival of the child with chronic illness or disability and the child's social role in a family and a community.

The Child's Role in the Family

Family attitudes toward the child's disability and expectations for the child's survival and social roles may determine the extent to which the family will invest in terms of time, energy, and resources (Groce & Zola, 1993). For example, if a family has a positive view of the child's disability and expects the child to live a normal life, the family will seek every opportunity and service for the child with a disability. Conversely, if another family holds a fatalistic view of the child's disability and does not expect the child to be an equal and contributing member of the family and community, the child's needs may be neglected. In some cultures a child with a disability, especially a child with a severe disability, is expected to live a dependent life in the family. The family may need to balance the needs of the other children at home when the family has limited resources; therefore, the other needs (e.g., social needs, education needs) of the child with a disability may not be met. In some cultures, a child's gender may also have a great impact on the family's efforts in seeking supports and services for the child. For example, Groce and Zola (1993) state that a Chinese family may go to greater lengths in meeting the needs of a son with a disability than those of a daughter.

The Child's Role in a Community

In many cultures, people with disabilities are not viewed as lesser members of society in their communities. Many Native Americans believe that as long as individuals make contributions to the group, no matter how insignificant, they are valued members of that community (McCubbin et. al., 1993). Anderson (1989) states that in some Hispanic communities, a child with a disability is not considered a burden. There is a strong value that all members are important in the community. Willis (1992) indicates that the attitudes and perceptions of the causation of disability do not have much effect on the interaction with families with children with disabilities in some African American communities. Many African families and communities have lived with and accepted individuals with disabilities for many years.

These examples suggest that the prevalent attitudes toward disability in a community do affect a family's way of life. In some communities where social integration of people with

disabilities is encouraged, families may be more directly or indirectly involved in seeking opportunities for their children with disabilities to live a normal life. However, if a community is hesitant to accept people with disabilities as equal members, families may be embarrassed to participate fully in the community. Keeping the child at home and not seen by the public may be a preferable choice for them (Groce & Zola, 1993).

A family's traditional beliefs, beliefs about health and healing, and expectations of their child's social roles are closely related to family decisions in participating in early intervention services, in placing the child in inclusive or segregated settings, and in seeking medical care for their child with a disability. These belief systems of families have serious implications for professionals when they work with families.

Conclusion

This report has discussed the perceptions of disability and views of health and healing of some culturally diverse families. Some of these values and beliefs are quite different from those in the European American culture. Early intervention professionals can improve their practice by developing an understanding of these perceptions in order to form partnerships with families. Because these beliefs and values greatly affect decision-making and childrearing and are certainly important variables in developing the IFSP/IEP for the child, it is crucial that professionals become better informed. The potential for forming full partnerships will be greatly expanded with this knowledge. Families from culturally diverse backgrounds will benefit greatly if professionals demonstrate empathy and understanding of their beliefs about health and perception of disability.

Traditional beliefs are not static. In fact, as Groce and Zola (1993) explain, "Traditional belief systems on disability have at times proved to be quite adaptive, shifting in response to social, economic, and educational experiences gained through the acculturation process" (p. 1054). Professionals do not need to read every book about traditional beliefs of each culture they work with; however, in order for families to be better served by early intervention, professionals need to be aware of and sensitive to belief systems, be they traditional or scientific. Finally, they need to facilitate understanding, respect, and empathy so as to bridge the differences between the families and the service delivery systems.

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It's a Three-Way Conversation: Families, Service Providers, and Interpreters Working Together

It's a Three-Way Conversation: Families, Service Providers, and Interpreters Working Together, Ohtake, Y., Milagros Santos, R., and Fowler, S. *Young Exceptional Children*, Volume 4, Number 1, Fall 2000, pp.18. The Division for Early Childhood of the Council for Exceptional Children and Sopris West. Denver, CO.

Table 2
Recommended Practices for Service Providers Working with Interpreters in Meetings

Context	Recommended Practice
Before the Meeting	<ul style="list-style-type: none"> • Have a list of interpreters available for families. • Encourage the family to choose an interpreter with whom they feel comfortable. • Discuss the importance of neutrality with the interpreter and other team members. • Encourage the interpreter and other team members to be self-reflective. • Provide the interpreter with written documents as advanced organizers. • Provide the interpreter with a glossary book of terms used in special education. • Support the interpreter's efforts in taking special education courses. • Discuss the duties and vital roles of interpreters and other team members.
During the Meeting	<ul style="list-style-type: none"> • Create an informal atmosphere. • Avoid using professional jargon. • Use visual aids and concrete examples. • Avoid idiomatic words, slang, and metaphors that are difficult to translate. • Be aware of lone words (e.g., slang terms such as "cool"). • Use simple sentences. • Speak slowly and clearly. • Use consecutive interpretation. • Encourage the interpreter to take notes and ask questions. • Be sensitive to reactions shown by the

interpreter to identify possible problems with interpretation.

- Maintain eye contact with the family.

After the Meeting

- Evaluate the meeting with the interpreter using the guidelines described in “Before the Meeting” and “During the Meeting.”
- Encourage the interpreter to ask questions to clarify issues about the meeting.
- Identify problems that the interpreter may have encountered during the meeting.
- Encourage the interpreter to advise you if you and other team members communicate with the family in a culturally inappropriate manner.
- Brainstorm ways to address problems for future meetings.

Notes

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A Personal Journey

We all have a cultural heritage that influences our beliefs, values, and approach to life. Understanding our own heritage can help as we seek to understand and demonstrate respect for the cultural heritage of others. Take a personal journey of your own by thinking back to your family of origin.... Be prepared to share and place in your portfolio.

Family Background, History, Origin

- When you think of your family, who is included?
- Where does your family come from? State, region, country?
- When you think about your roots, what country(ies) other than the USA do you identify as a place of origin for you or your family?
- What languages are/were spoken in your home? What languages were lost?
- How do you feel your roots influence your behavior today?

Health

- What happened in your family when someone was ill or sick?

- How did your family seek help when someone was ill?
- How did your parents view disabilities?

Food

- What were the rules about eating when you were a child?
- What foods do you associate with your traditions, heritage, or cultural background? What is the significance of those foods?

Celebrations or Rituals

- What celebrations, traditions, ceremonies, rituals, or holidays did your family observe that reflected your culture, religion, country, or family background? How were they observed?
- How are you passing along special traditions to your family? What are they? Why are they important to you?

Colorado Service Coordination Training Module 4 A Cultural Journey (5/9/01)

This handout was adapted from several sources, especially: Lynch, E.W. & Hanson, M.J. (1998) Developing Cross-Cultural Competence.

This handout was further adapted with permission for Tennessee's Early Intervention Service Coordination Training (March 2004).